

Illinois Department of Public Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008684 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 03/16/2016 |
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| NAME OF PROVIDER OR SUPPLIER RUSHVILLE NURSING & REHAB CTR | STREET ADDRESS, CITY, STATE, ZIP CODE 135 SOUTH MORGAN STREET RUSHVILLE, IL 62681 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------------|---|---------------------|--|--------------------------|
| S 000 | Initial Comments | S 000 | | |
| | Second Probationary Licensure Survey | | | |
| S9999 | Final Observations | S9999 | | |
| | <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)</p> <p>This requirement is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to immediately report an allegation of abuse for one of three abuse allegations reviewed. This failure affects one resident (R105).</p> <p>Findings include:</p> <p>The facility's Abuse Prevention Program policy (dated 12/2013) documents the following: "Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, mistreatment or misappropriation of resident property they observe, hear about or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator..."</p> <p>R105's initial Abuse Allegation report (dated 1/24/16 at 5:04 PM) documents the following: "(R105) states staff member yelled at (R105). Abuse investigation has begun. Staff member (E3, Licensed Practical Nurse) suspended pending investigation."</p> | | | |

Attachment A
Statement of Licensure Violations

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| Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | <p>Continued From page 1</p> <p>R105's Abuse Investigation documents the following statement by E4 (Certified Nursing Aide): "1/24/16: About 5:30 this morning, (R105) went to the (Certified Nursing Assistant) station and asked for help with (R105)'s lights; (R105) said there was a switch by the desk. I (E4) told (R105) that I(E4) would have to ask someone where it was because I (E4) didn't know what (R105) meant. E3 (Licensed Practical Nurse) turned around and told (R105) there 'wasn't any f***king switch' and the day shift girls were lying to (R105) about it. (R105) tried to explain what (R105) meant and (E3) started yelling at (R105)..."</p> <p>R105's Abuse Investigation (dated 1/24/16) documents the following statement by E1 (Administrator): "(E6, Former Director of Nursing) texted me (E1) on Sunday, 1/24/16 at 3:55 PM stating R105 told E5 (Licensed Practical Nurse) this morning that (E3) talked awful to (R105) last night about the power being out in (R105)'s room... 'I (E5) showed the night Certified Nursing Assistant (E4) so (E4) knows next time. (E4) even said (E3) was shouting and (E4) was scared to say anything because (E4) has to work with (E3)..."</p> <p>On 3/15/16 at 11:40 AM, E1 (Administrator) verified that R105's incident occurred at 5:30 AM on 1/24/16. E1 also verified that neither E4 (Certified Nursing Assistant) nor E5 (Licensed Practical Nurse) immediately reported R105's incident to E1 upon becoming aware of the situation and that R105's allegation should have immediately been reported to E1.</p> <p>(B)</p> | S9999 | | |

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